INITIAL APPLICATION FOR CLINICAL PRIVILEGES

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10,USC, Section 1071.

Principal Purpose To define the extent and limits of the practitioner's clinical privileges as a function of his or her training and experience.

Routine Uses: Determine and assess capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hospitals, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulating bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*	2. SOCIAL SECURITY NO. *(SSN)*	3. GRADE

4. CORPS	5. DATE OF ASSIGNMENT *(Day, Mo., Yr.)*	6. ASSIGNMENT LOCATION
		DARNALL ARMY COMMUNITY HOSPITAL FORT HOOD, TEXAS 76544-5063

SECTION B - PROFESSIONAL EDUCATION

7. NAME OF PROFESSIONAL SCHOOL	8. LOCATION	9. YRS. ATTENDED		10. TYPE DEGREE	11. DEGREE COMPLETED *(Day, Mo., Yr.)*
		FROM	TO		

SECTION C - POSTGRADUATE TRAINING

12. NAME OF HOSPITAL OR INSTITUTION	13. LOCATION	14. TYPE PROGRAM *(Residency, etc.)*	15. DURATION	16. DATE COMPLETED *(Day, Mo., Yr.)*

SECTION D - PREVIOUS HOSPITAL ASSIGNMENTS

17. NAME OF HOSPITAL	18. LOCATION	19. CLINICAL SERVICE/DEPT. ASSIGNED	20. INCLUSIVE DATES *(Day, Mo., Yr.)*	
			FROM	TO

DATE OF BIRTH:

SECTION E - CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

21. BOARD ELIGIBLE FROM *(Date)*	22a. BOARD EXAM TAKEN *(Date)*	22b. CHECK	24. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*
		☐ Total ☐ Partial	

23. BOARD CERTIFIED? *(If yes, give name of Board(s).*

☐ Yes ☐ No

SECTION F - CREDENTIALS ACTION HISTORY *(If "yes" to any of the following, give full details on a separate sheet.)*

		YES	NO			YES	NO
25.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, or voluntarily surrendered?			28.	Have your privileges at any institution ever been limited, restricted or revoked?		
26.	Have you ever refused membership in a hospital medical staff?			29.	Has your narcotics registration ever been suspended or revoked?		
27.	Has your request for any specific clinical privileges ever been denied or granted with stated limitations?			30.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?		

SECTION G - CLINICAL PRIVILEGES APPLIED FOR

31. LIST THE APPROPRIATE DA FORM 5440-R-SERIES AND ATTACH TO THIS FORM

32a. DEA NO. *(If any)*	32b. DATE	33a. STATE LICENSURE *(If any)*	33b. DATE	33c. EXPIRATION DATE
The information contained herein is true to the best of my knowledge and belief.		34a. SIGNATURE OF APPLICANT		34b. DATE

35. Recommendations

a. PROVISIONAL STATUS	FROM	TO	b. CLINICAL PRIVILEGES ☐ Granted as Requested. ☐ Modified *(Specify in item 28c.)*

c. MODIFICATIONS

36. Reviewed By

a. DEPARTMENT/SERVICE	b. DATE	d. CREDENTIALS COMMITTEE *(Signature)*	e. DATE
c. SIGNATURE		**37. Approved By** a. HOSPITAL/DENTAC COMMANDER *(Signature)*	b. DATE

38. Appointment Status

a. CLINICAL PRIVILEGES

☐ Granted as Requested. ☐ Modified *(Specify in item 38b.)*

b. MODIFICATIONS

39. Reviewed By

d. DEPARTMENT/SERVICE	e. DATE	d. CREDENTIALS COMMITTEE *(Signature)*	e. DATE
c. SIGNATURE		**40. Approved By** a. HOSPITAL/DENTAC COMMANDER *(Signature)*	b. DATE

DELINEATION OF PRIVILEGES RECORD

For use of this form, see AR 40-68; the proponent agency is OTSG

1. PERIOD From To

2. Check the Appropriate Category

	A. Anesthesia		I. Pediatrics		Q. Nurse Practitioners *(Adult)*
	B. Dentistry		J. Podiatry		R. Nurse Practitioners *(Pediatric)*
	C. Family Practice		K. Psychiatry		S. OB/GYN Nurse Practitioners
	D. Internal Medicine & Subspecialty		L. Psychology		T. Physician Assistants
	E. Neurology		M. Radiology/Nuclear Medicine		U. Emergency Medicine
	F. Obstetrics & Gynecology		N. Surgery		V. Other Specialty *(Specify)*
	G. Optometry Service		O. Nurse Anesthetists		
	H. Pathology		P. Nurse Midwives		

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC	B. APPOINTMENT TYPE	C. CLINICAL PRIVILEGES
DARNALL ARMY COMMUNITY HOSPITAL USA MEDDAC 36000 DARNALL LOOP FORT HOOD, TEXAS 76544-4752	☐ (1) Initial ☐ (2) Active ☐ (3) Affiliate ☐ (4) None	☐ (1) Regular ☐ (2) Temporary ☐ (3) Supervised

D. DEPT./SVC *(Specify)*	E. DATE	G. CREDENTIALS COMMITTEE	H. DATE

F. SIGNATURE	I. SIGNATURE

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER	B. SIGNATURE	C. DATE

5. Remarks ADMITTING PRIVILEGES ___YES ___NO Clinical Privileges: ___Granted as Requested ___Modified as Recommended

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM *(Date)*	B. BOARD EXAMINATION TAKEN *(Date)*	C. BOARD CERTIFIED
	___Total ___Partial	___No ___Yes (Give name of Board)

D. RECERTIFICATION *(Board and Date)*	E. UTILIZED IN PRIMARY SPECIALTY	F. YEARS AND DATES OF SPECIALTY TRAINING *(Specify only training since initial application)*

G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD	H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD *(Specify)*	J. NAME OF APPLICANT OR PRACTITIONER

I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) *(Specify)*	K. SIGNATURE	L. DATE

USAR OR ARNG APPLICATION FOR CLINICAL PRIVILEGES TO PERFORM ACTIVE OR INACTIVE DUTY TRAINING

For use of this form, see AR 40-68; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title, 5, United States Code (USC), Sections 301; Title 44, USC, Section 3101; and Title 10, USC, Section 1071.

Principal Purpose: To define the extent and limits of the practitioner's clinical privileges as a function of his or her training experience.

Routine Uses: Determine and asses capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hopitals, the Federation of State Medical Boards of the U.S., State Licensure authorities, and other appropriate professional regulating bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

SECTION A - IDENTIFICATION

1. NAME *(Last, first, middle)*	2. SOCIAL SECURITY NO. *(SSN)*	3. DOB	4. GRADE

5. CORPS	6. UNIT IDENTIFICATION	7. SPECIALTY BY TRAINING

SECTION B - BASIC INFORMATION

8. LICENSURE/CERT.		9. DATE(S)	10. EXPIRATION DATE(S)
a. State Licensure *(If any)*			
b. DEA Number *(If any)*			
c. CPR Certificate			
d. ACLS Certificate			
e. BCLS Certificate			

11. BOARD ELIGIBLE FROM *(Date)*	12a. BOARD EXAM TAKEN *(Date)*	12b. CHECK ☐ Total ☐ Partial	14. MEMBERSHIP IN SPECIALTY SOCIETIES *(Specify)*

13. BOARD CERTIFIED? *(If yes, give name of Board(s).*
☐ Yes ☐ No

15. Current Hospital Privileges

a. NAME OF HOSPITAL	b. LOCATION	c. TYPE OF APPOINTMENT

16. Interval information *(If Yes to any of the following questions, give full details on a seperate sheet of paper.)*

In the last year, have you:	YES	NO
a. Have you had any final unfavorable liability judgments?		
b. If yes, any liability payments above $100,000?		
c. Have you been the subject of any disciplinary action by any local or state medical society or any licensing agency?		
d. Have you had you clinical privileges limited, revooked, or otherwise modified at any institution?		
e. Resigned from the staff of any hospital?		
f. Been treated for drug or alcohol abuse?		
g. Not maintained you state's continuing medical education requirements?		

	YES	NO
h. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Outpatient Clinic**?		
i. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the **Emergency Care area**?		
j. Do you certify that you are mentally and physically able to practice medicine?		

17. COMMENTS

The information contained herein is true to the best of my knowledge and belief.	18a. SIGNATURE OF APPLICANT	18b. DATE

SECTION C - ARNG OR USAR UNIT COMMANDER'S RECOMMENDATIONS

That clinical privileges be granted to the named applicant for Active or Inactive duty.

1. NAME

2. PERIOD

FROM

TO

3. MEDICAL TREATMENT FACILITY OR DENTAC

4. BY EDUCATION AND TRAINING, THIS PRACTITIONER IS QUALIFIED IN THE FOLLOWING

SPECIALTIES	UN-KNOWN	YES	NO
a. Primary →			
b. Secondary →			
6. This practitioner has the capability of performing the medical duties required of a General Medical Officer or General Dentist.			
7. All documents of education, training, licensure/certification/registration and ECFMG (if applicable) have been verified with a primary source.			

5. PRACTITIONER'S DEMONSTRATED CLINICAL COMPETENCY REMARKS

THIS PRACTITIONER IS PHYSICALLY, MENTALLY AND CLINICALLY COMPENTENT TO PERFORM THE DUTIES THAT HE/SHE IS ASSIGNED TO DO.

8a. NAME OF VERIFYING INDIVIDUAL	8b. GRADE	8e. SIGNATURE
8c. TITLE	8d. DATE	
9a. NAME OF UNIT COMMANDER	9b. GRADE	9e. SIGNATURE
9c. TITLE	9d. DATE	

SECTION D - RECOMMENDATIONS OF SITE CREDENTIALS COMMITTEE

10. REMARKS

11. RECOMENDED STATUS

☐ Conditional ☒ Full

12. CLINICAL PRIVILEGES RECOMMENDED

☐ As Requested ☐ Other *(Specify in Item 12.)*

13a. NAME OF CREDENTIALS COMMITTEE CHAIR	13b. GRADE
13c. SIGNATURE	13d. DATE

SECTION E - APPROVING AUTHORITY

14a. NAME OF MTF OR DENTAC COMMANDER	14b. SIGNATURE	14c. DATE

MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

For use of this form, see AR 40-68, the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT 1974

Authority:	Title 5, United States Code (USC), Sections 3109 and 3301. (Title 5, USC, Section 552a)
Principle Purpose:	To obtain U.S. Civil Service appointment.
Routine Uses:	Basis for determination of qualifications and background information for the eligibility for appointment. Basis or credentialing health care providers.
Disclosure:	Disclosure of information requested is voluntary. However, failure to provide the required information will result in nonacceptability of the application.

The policy of the Army is to screen, verify and validate statements, assertions and documents of all applicants for health care provider positions. As part of this process, please complete the following statements (as applicable to your profession).

1. NAME OF INDIVIDUAL	2. SOCIAL SECURITY NUMBER (SSN)

HAVE (YES)	HAVE NOT (NO)	STATEMENTS
		3. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice. **(If affirmative explain each incident in item 13 below.)**
		4. I am licensed/registered/certified by the authority named in item 13 below. **(List all current and past licenses held, include issue and expiration date. Explain the suspension or revocation of licensure previously held.)**
		5. Had my professional license denied, withdrawn or restricted voluntarily/involuntarily by a state or local licensing board or other authority. **(If affirmative, give the organization name, address and dates involved in item 13 below.)**
		6. Had professional privileges denied, withdrawn, or restricted voluntarily/involuntarily by a health care facility. **(If affirmative, give the organization name, address, and dates involved in item 13 below.)**
		7. Resigned or otherwise disassociated myself from employment or practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. **(If affirmative, give organization name, address and dates involved in item 13 below.)**
		8. Are you now or have you ever been required to appear before any medical or state regulating authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted practitioner? **(If affirmative, give brief explanation in item 13 below.)**
		9. Had a history of drug or alcohol abuse or misuse. **(If affirmative, explain in item 13 below.)**
		10. Do you have any disease or impairments which make your employment a hazard to yourself or other? **(If affirmative, please list in item 13 below.)** In addition, please provide a brief description of your health status as it pertains to the privileges being requested.
		11. I hereby authorize the U.S. Army to contact my current and previous malpractice carrier/licensing organizations for the purpose of verifying the above information.
		11a. CARRIERS (Name and Address - current and previous) / 11b. Policy Number: — 11c. LICENSING ORGANIZATIONS (Name and Address current and previous)
		12. I hereby authorize the U.S. Army to contact the following institution(s) for the purpose of verifying the status of my current professional privileges:
		12a. ORGANIZATION (Name and Address) — 12b. DATE(S)

13. CLARIFICATIONS, EXPLANATIONS, ETC. REGARDING ITEMS 3-10 ABOVE. (Identify by appropriate number, continue on reverse if necessary.)

#4. List all current and past licenses ever held. Include issue and expiration date.

#10. Please provide a brief description of your health status as it pertains to the privileges being requested.

14a. TYPED/PRINTED NAME OF APPLICANT	14b. SIGNATURE OF APPLICANT	14c. DATE